2019
COMPARISON CHART

Individual & Family Products

An Independent Licensee of the Blue Cross and Blue Shield Association

PLAN DESCRIPTION

Our plans are designed for Arizonans in every stage of life. Choose a plan that works best for you or your family. All of the plans include coverage for preventive care at no out-of-pocket cost to you*.

Choose Blue and get coverage for doctor visits, prescription drugs, preventive care, hospital stays, maternity and newborn care, mental and behavioral health, emergency and urgent care, and dental and vision care for children.**

The plans below are HMO plans. You need to visit doctors or hospitals in your network in most cases for care to be covered. HMO plans do not cover care by doctors or hospitals outside your network, except for emergencies and other special cases when use is preapproved.

EverydayHealth

EverydayHealth HMO is our most popular health plan for individuals and families. The EverydayHealth plan offers **copays** for most routine care with doctors in your network. A deductible and coinsurance may apply for major healthcare services and procedures. EverydayHealth may be right for you and your family if you:

- Want low out-of-pocket costs for doctor visits and prescription drugs, and
- Need financial protection in case you have an emergency or a major medical issue
- Want broad coverage, but don't want to pay too much each month for your premium

TrueHealth

TrueHealth HMO is a brand new health plan for individuals and families. The TrueHealth Silver plan offers convenient copays for most routine care and prescription drugs without a separate drug deductible. For most major health care including surgeries you will need to meet your deductible before the plan begins to pay for care. TrueHealth may be right for you and your family if you:

- Want a lower premium even if that means a higher deductible, and
- Predictable costs for doctor visits and most prescription drugs

Portfolio HSA

Portfolio HSA HMO is a health plan designed to be paired with a Health Savings Account (HSA), which has certain tax advantages. For most healthcare you will need to meet your deductible before the health plan begins to pay for care. Portfolio HSA may be right for you and your family if you:

- Want to pair your health plan with a Health Savings Account, and either
- Don't expect frequent doctor visits or prescriptions, or
- Do expect higher health costs and want to use a Health Savings Account for its tax advantages

SimpleHealth

SimpleHealth HMO is a health plan that is available only to individuals who are under age 30 or have met a hardship exemption. SimpleHealth may be right for you and your family if you:

- Are all under age 30
- Are likely to visit your doctor fewer than four times in a year and plan to visit doctors in your network
- Want the lowest possible monthly premium, even if that means possibly paying more when you do need health care

This is only a brief summary of the benefit plans, and is designed to help you compare features of different plans. All plans are subject to the limitations and exclusions listed on page 9 of this summary. More detailed information about benefits, cost share, exclusions and limitations is in the benefit plan booklets and plans. Summary of Benefits and Coverage (SBC) and benefit plan booklets are available on request or at azblue.com/2019INDbooks. If the terms of this summary differ from the terms of the benefit plan booklets, the terms of the booklets control and apply.

*Preventive care must be from doctors or hospitals in your network. Applies to covered services performed for a preventive diagnosis as required under state or federal law.
** All plans are subject to limitations, exceptions and cost share requirements.

PLAN AVAILABILITY

Important Plan Availability Information

Blue Cross Blue Shield of Arizona individual and family plans are not available for sale to residents of Maricopa County in 2019.

Residents in Maricopa County should visit Healthcare.gov to see plans that are available.

All counties except for Maricopa County and Pima County	Pima County
EverydayHealth HMO 2000 – Neighborhood Network	EverydayHealth HMO 2000 – PimaFocus Network
EverydayHealth HMO 4000 – Neighborhood Network	EverydayHealth HMO 4000 – PimaFocus Network
EverydayHealth HMO 6500 – Neighborhood Network	EverydayHealth HMO 6500 – PimaFocus Network
TrueHealth HMO 6000 – Neighborhood Network	TrueHealth HMO 6000 – PimaFocus Network
Portfolio HSA HMO 5850 – Neighborhood Network	Portfolio HSA HMO 5850 – PimaFocus Network
SimpleHealth HMO[1] – Neighborhood Network	SimpleHealth HMO[1] – PimaFocus Network

Important Network Information

HMO plans do not cover services from providers who are not in the network, except for emergencies and certain limited cases when preapproved by BCBSAZ.

The **Neighborhood Network** includes doctors and hospitals throughout the state. Neighborhood Network plan options are not available to residents of Maricopa and Pima Counties. Go to azblue.com/Neighborhood to see the providers in the Neighborhood Network.

Most providers in the **PimaFocus Network** are located in Pima County. PimaFocus Network plan options are not available to residents outside of Pima County. Go to azblue.com/PimaFocus to see the providers in the PimaFocus Network.

[1] SimpleHealth is a catastrophic plan. Catastrophic plans are available only for people who are under age 30 before their first day of coverage, or who are exempt from the insurance mandate. If you think you are exempt from the insurance mandate and wish to apply for SimpleHealth, you will need to submit a completed hardship exemption form and supporting documentation. Hardship exemption forms can be found at healthcare.gov.

PLAN YOUR CARE

Primary Care Provider Assignment

Your primary care provider (PCP) is your point person coordinating care with your other specialists. Coverage from a non-designated primary care provider will not be covered except for providers within the same practice. To help you get started we will select one for you, but if you want to change your PCP you can. When your PCP is your health care partner, you can feel confident that you are getting consistent advice and efficient care. Log on to azblue.com/member to look up or change your primary care provider.

Specialist Referrals

Members are required to get a referral from their PCP to see most in-network specialists. If you need to see a specialist, it's important to get a referral from your primary care provider to avoid surprise charges – even if you're currently seeing a specialist. Once you have confirmed the referral was approved, you can call the specialist to schedule an appointment. Log on to azblue.com/member to check on the status of a referral.

In-Network Coverage

Don't pay more than you should. Check that your doctor is in your plan's network before you go. When you see a doctor in your network, you'll have no out-of-pocket costs for preventive services: $0 checkups, $0 flu shots, $0 immunizations, $0 women's well checks, $0 mammograms, $0 blood pressure tests and $0 cholesterol screenings.*

HMO plans have no out of network and out of state coverage except for urgent and emergency care. Always check that your doctor or specialist is in your plan's network to avoid facing unexpected costs. Staying "in-network" means you can feel good knowing your doctor takes your insurance. Visit azblue.com/member to see if your doctor is in your plan's network or to find one who is.

*Applies to covered services performed for a preventive diagnosis as required by state or federal law.

The charts on the following pages show only network cost share amounts, and are designed to help you compare key network features of different plans. The charts do not show all benefits or plan terms. HMO plans do not cover services outside your network except for emergency care and other special circumstances when use is preapproved.

Copays for the most common health care needs such as doctor visits and generic prescriptions when you use providers in your network.

	EverydayHealth 2000	EverydayHealth 4000	EverydayHealth 6500
Calendar Year Deductible The amount you pay for covered services before the plan begins to pay. After you meet the deductible, you pay coinsurance. Copays are separate from the deductible and do not count towards the deductible.	$2,000/member and $4,000/family	$4,000/member and $8,000/family	$6,500/member and $13,000/family
Metal Level	Gold ($$$)	Silver ($$)	Bronze ($)
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a copay or different coinsurance applies.	20% after deductible	20% after deductible	10% after deductible
Out-of-Pocket Limit The most you will pay in a calendar year for all covered services. This does not include premiums, precertification charges, or balance bills.	$6,000/member and $12,000/family	$6,650/member and $13,300/family	$7,900/member and $15,800/family
Primary Care Provider/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other providers are specialists.	$15 copay	$20 copay	$30 copay
Specialist A provider or other health care professional who practices in a specific area other than those practiced by primary care providers.	$60 copay	$60 copay	$100 copay
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	$60 copay	$60 copay	$100 copay
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The provider determines whether a service is considered preventive.	No charge, deductible waived	No charge, deductible waived	No charge, deductible waived
Prescription Drug Deductible for Level 2 and 3 drugs	$350/member	$450/member	$650/member
Prescription Drugs	Level 1: $10 copay Level 2: $60 copay after deductible Level 3: 40% after deductible	Level 1: $15 copay Level 2: $60 copay after deductible Level 3: 40% after deductible	Level 1: $35 copay Level 2: $100 copay after deductible Level 3: 40% after deductible
Specialty Drugs	50%, deductible waived	50%, deductible waived	50%, deductible waived
Surgery (Inpatient/Outpatient)	20% after deductible	20% after deductible	10% after deductible
Emergency Room Visit	20% after deductible	20% after deductible	10% after deductible
Ambulance	20%, deductible waived	20%, deductible waived	10%, deductible waived
Maternity	$60 copay for all services included in the provider's global delivery charge, and 20% after deductible for all other services	$60 copay for all services included in the provider's global delivery charge, and 20% after deductible for all other services	$100 copay for all services included in the provider's global delivery charge, and 10% after deductible for all other services
Pediatric Routine Vision 1 exam per year	$15 copay	$20 copay	$30 copay
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. See page 10 for more details.	Diagnostic & Preventive: No charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No charge Restorative & Orthodontia: 50% after deductible	Diagnostic & Preventive: No charge Restorative & Orthodontia: 50% after deductible

Cost share amounts are for covered services by doctors and hospitals in your network. Services by healthcare professionals outside your network are generally not covered except for emergencies and other special circumstances when use is preapproved. Only formulary drugs are covered unless a formulary exception is approved. If you are on a plan with a copay drug benefit and pick a brand medication when a generic is available, you will pay the difference in cost, plus your copay and any applicable deductible. All plans are subject to the limitations and exclusions listed on page 9 of this summary.

Predictable costs for doctor visits and most prescription drugs without a separate prescription drug deductible. Lower cost plan, more likely to use preferred brand drugs.

	TrueHealth 6000
Calendar Year Deductible The amount you pay for covered services before the plan begins to pay. After you meet the deductible you pay coinsurance.	$6,000/member and $12,000/family
Metal Level	Silver ($$)
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a different coinsurance applies.	No charge after deductible
Out-of-Pocket Limit The most you will pay in a calendar year for all covered services. This does not include premiums, precertification charges, or balance bills.	$6,500/member and $13,000/family
Primary Care Provider/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other providers are specialists.	$25 copay
Specialist A provider or other health care professional who practices in a specific area other than those practiced by primary care providers.	$100 copay
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	$100 copay
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The provider determines whether a service is considered preventive.	No charge, deductible waived
Prescription	Level 1: $25 copay Level 2: $100 copay Level 3: No charge after deductible
Specialty Drugs	50%, deductible waived
Surgery (Inpatient/Outpatient)	No charge after deductible
Emergency Room Visit	No charge after deductible
Ambulance	No charge after deductible
Maternity	$100 copay for all services included in the provider's global delivery charge, and no charge after deductible for all other services
Pediatric Routine Vision 1 exam per year	$25 copay
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. See page 10 for more details.	Diagnostic & Preventive: No charge Restorative & Orthodontia: No charge after deductible

Cost share amounts are for covered services by doctors and hospitals in your network. Services by healthcare professionals outside your network are generally not covered except for emergencies and other special circumstances when use is preapproved. Only formulary drugs are covered unless a formulary exception is approved. If you are on a plan with a copay drug benefit and pick a brand medication when a generic is available, you will pay the difference in cost, plus your copay and any applicable deductible. All plans are subject to the limitations and exclusions listed on page 9 of this summary.

A low premium plan eligible for use with a Health Savings Account (HSA) from a qualified financial institution. This plan provides flexibility on how your healthcare dollars are spent while offering potential tax savings when paired with an HSA. Many preventive services are covered at no out-of-pocket cost to you.*

	Portfolio 5850
Calendar Year Deductible The amount you pay for covered services before the plan begins to pay. After you meet the deductible you pay coinsurance.	$5,850/member and $11,700/family
Metal Level	Bronze ($)
Coinsurance Percentage paid for certain covered services after meeting the deductible, unless a different coinsurance applies.	10% after deductible
Out-of-Pocket Limit The most you will pay in a calendar year for all covered services. This does not include premiums, precertification charges, or balance bills.	$6,750/member and $13,500/family
Primary Care Provider/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other providers are specialists.	10% after deductible
Specialist A provider or other health care professional who practices in a specific area other than those practiced by primary care providers.	10% after deductible
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	10% after deductible
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The provider determines whether a service is considered preventive.	No charge, deductible waived
Prescription and Specialty Drugs	10% after deductible
Surgery (Inpatient/Outpatient)	10% after deductible
Emergency Room Visit	10% after deductible
Ambulance	10% after deductible
Maternity	10% after deductible
Pediatric Routine Vision 1 exam per year	10% after deductible
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. See page 10 for more details.	Diagnostic & Preventive: 10% after deductible Restorative & Orthodontia: 50% after deductible

*Cost shared is waived for many preventive services by doctors and hospitals in your network.

Cost share amounts are for covered services by doctors and hospitals in your network. Services by healthcare professionals outside your network are generally not covered except for emergencies and other special circumstances when use is preapproved. Only formulary drugs are covered unless a formulary exception is approved. All plans are subject to the limitations and exclusions listed on page 9 of this summary.

Available only to people under age 30 or who receive an exemption from the individual mandate through the Health Insurance Marketplace. A fixed copay is available for your first three visits to a primary care provider.

	SimpleHealth
Calendar Year Deductible The amount you pay for covered services before the plan begins to pay. Copays are separate from the deductible and do not count towards the deductible.	$7,900/member and $15,800/family
Metal Level	Catastrophic ($)
Out-of-Pocket Limit The most you will pay in a calendar year for all covered services. This does not include premiums, precertification charges, or balance bills.	$7,900/member and $15,800/family
Primary Care Provider/Pediatrician Includes internal medicine, family practice, general practice, and pediatricians. All other providers are specialists.	$20 for first three office visits then no charge after deductible
Specialist A provider or other health care professional who practices in a specific area other than those practiced by primary care providers.	No charge after deductible
Urgent Care Visit Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.	No charge after deductible
Preventive Services Performed for screening purposes before any signs or symptoms of a condition or disease appear. The provider determines whether a service is considered preventive.	No charge, deductible waived
Prescription and Specialty Drugs	No charge after deductible
Surgery (Inpatient/Outpatient)	No charge after deductible
Emergency Room Visit	No charge after deductible
Ambulance	No charge after deductible
Maternity	No charge after deductible
Pediatric Routine Vision 1 exam per year	No charge after deductible
Pediatric Dental 2 check-ups and cleanings per year. Services covered for members under age 19. See page 10 for more details.	Diagnostic & Preventive: No charge after deductible Restorative & Orthodontia: No charge after deductible

Cost share amounts are for covered services by doctors and hospitals in your network. Services by healthcare professionals outside your network are generally not covered except for emergencies and other special circumstances when use is preapproved. Only formulary drugs are covered unless a formulary exception is approved. All plans are subject to the limitations and exclusions listed on page 9 of this summary.

IMPORTANT INFORMATION

Allowed Amount

All claims are processed using the BCBSAZ "Allowed Amount." BCBSAZ reimbursement, member cost share payments, and accumulations toward deductibles and out-of-pocket limits are calculated on the BCBSAZ Allowed Amount. The allowed amount is the total amount of reimbursement allocated to a covered service and includes both the BCBSAZ payment and the member cost share payment. It does not include any balance bill. The allowed amount is based on BCBSAZ or other fee schedules. It is not tied to and does not necessarily reflect a provider's regular billed charges.

Providers, Claims and Out-of-pocket Costs

All healthcare professionals in your network, also known as network providers are independent contractors exercising independent medical judgment and are not employees, agents or representatives of BCBSAZ. BCBSAZ has no control over any diagnosis, treatment or service rendered by any provider. Network providers will file members' claims and generally cannot charge more than the allowed amount for covered services. Services from healthcare professionals outside your network are not covered on HMO plans except for emergencies and in limited circumstances when preapproved by BCBSAZ.

Primary Care Provider

BCBSAZ requires selection of a primary care provider (PCP). BCBSAZ will assign a PCP for you. After initial PCP assignment, you can change your PCP by contacting BCBSAZ six (6) additional times during any calendar year. You have the right to select any PCP who participates in our network and who is currently accepting new patients. For information on how to select a PCP and for a list of network PCPs, contact BCBSAZ Customer Service or visit the BCBSAZ website at azblue.com/member.

Specialist Services

A referral from your designated PCP is required for non-emergent and non-urgent Specialist services. The requirement to obtain a referral from your designated PCP does not apply to services from providers who specialize in obstetrics or gynecology, chiropractic services, outpatient mental health services, pediatric dental and vision services, urgent care, and services provided by walk-in clinics. If you do not obtain a referral from your designated PCP for services that require a referral, the services will not be covered under this benefit plan and you will be responsible for paying the provider's billed charges for those services.

Emergency Services

For emergency services, you will pay your network cost share, even if services are received from healthcare providers outside your network.

Precertification

Some services and medications require preapproval, also known as precertification. Except for emergencies, urgent care, and maternity admissions, precertification is always required for inpatient admissions (acute care, behavioral health, long-term acute care, extended active rehabilitation, and skilled nursing facilities), home health services, and most specialty medications. Precertification may be required for other covered services and medications. Information on precertification requirements, including a list of medications that require precertification, and the process for obtaining precertification are available on the BCBSAZ website at azblue.com. You may also call BCBSAZ at (844) 807-5106 or (800) 232-2345, ext. 4273 for precertification of medications, or (800) 232-2345 (Statewide) for precertification of all other medical services.

Medications and Prescriptions

BCBSAZ applies limitations to certain prescription medications obtained through the pharmacy benefit. A list of these medications and limitations is available online at azblue.com or by calling BCBSAZ. These limitations include, but are not limited to, quantity, age, gender, dosage and frequency of refills. Prescription drugs are only covered if they are on the drug formulary (a list of drugs that BCBSAZ and/or the pharmacy benefits manager has designated as covered under the pharmacy benefit) unless a formulary exception is approved. BCBSAZ prescription medication limitations are subject to change at any time without prior notice.

Qualified Health Plan

BCBSAZ is a qualified health plan issuer in the Health Insurance Marketplace. All BCBSAZ individual and family plans are qualified health plans available through the Health Insurance Marketplace.

IMPORTANT WARNING

THIS IS ONLY A BRIEF SUMMARY OF THE BENEFIT PLANS, AND IS DESIGNED TO HELP YOU COMPARE FEATURES OF DIFFERENT PLANS. MORE DETAILED INFORMATION ABOUT BENEFITS, COST SHARE, EXCLUSIONS AND LIMITATIONS IS IN THE BENEFIT PLAN BOOKLETS AND PLAN SUMMARY OF BENEFITS AND COVERAGE (SBCS). BENEFIT PLAN BOOKLETS AND SBCS ARE AVAILABLE UPON REQUEST AND ON AZBLUE.COM/2019INDBOOKS. IF THE TERMS OF THIS SUMMARY DIFFER FROM THE TERMS OF THE BENEFIT PLAN BOOKLETS, THE TERMS OF THE BOOKLETS CONTROL AND APPLY.

EXCLUSIONS AND LIMITATIONS

Examples of services and supplies not covered

The following is a partial list of conditions and services that are excluded or limited. Expenses for services that exceed the benefit limits are not covered. Detailed information about benefits, exclusions and limitations is in the benefit plan booklets and is available upon request.

- Abortion
- Acupuncture
- Adult Routine Vision
- Alternative medicine
- Care that is not medically necessary
- Chiropractic services exceeding 20 visits per calendar year
- Cosmetic surgery, services & supplies
- Custodial care
- Dental care except as stated in plan and adult orthodontic services
- DME rental/repair charges that exceed DME allowed amount
- Experimental and investigational treatments
- Eye wear, except as stated in plan
- Fertility and infertility medication and treatment
- Flat feet treatment and services
- Genetic and chromosomal testing
- Habilitation outpatient services exceeding 60 visits per calendar year
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours) per calendar year
- Inpatient EAR & SNF treatment exceeding 90 combined days per calendar year
- Long-term care except long-term acute care
- Massage therapy other than allowed under medical coverage guidelines
- Non-emergency care when traveling outside the U.S.
- Orthodontic services (Pediatric) that are not dentally necessary
- Pediatric dental check-ups exceeding 2 check-ups and cleanings per calendar year
- Pediatric glasses or contact lenses exceeding 1 pair of glasses or contact lenses per calendar year
- Pediatric routine vision exam exceeding 1 visit per calendar year
- Private-duty nursing except when medically necessary or when skilled nursing not available
- Rehabilitation outpatient services exceeding 60 visits per calendar year
- Respite care
- Routine foot care
- Services from providers outside the network, except in emergencies and other limited situations when use is preapproved
- Sexual dysfunction treatment and services
- Weight loss programs

Dental benefits for children under age 19

Pediatric dental benefits are now included with your Blue Cross Blue Shield of Arizona (BCBSAZ) medical plan! All BCBSAZ 2019 Qualified Health Plans include dental coverage for children under age 19. Pediatric dental benefits described below are covered with healthcare professionals in your network only.

Type I Covered Services – Diagnostic and Preventive	
Oral exams	Two per year[1] in any combination of periodic, limited, or comprehensive exams
Prophylaxis – Cleanings	Two per year
X-rays	Any combination of x-rays billed on the same date of treatment cannot exceed the allowed amount for a full mouth x-ray benefit
Bitewing X-rays	Two sets per year
Periapical X-rays	Covered
Full-mouth X-rays	One set per five year period
Panoramic X-rays	One set per five year period. Panoramic x-rays accompanied by bitewing x-rays are considered a set of full-mouth x-rays and are subject to the full-mouth x-ray limit.
Topical Fluoride	Two treatments per year
Sealants	Permanent molars with no decay or restoration only. One application per three year period.
Space Maintainers	Temporary appliances to replace prematurely lost teeth until permanent teeth erupt.
Type II and III Covered Services – Restorative All claims subject to processing based on the least expensive available treatment (LEAT).[2]	
Restorative Fillings	Amalgam and composite resin fillings covered
Simple and Surgical Extractions	Covered
Periodontics – Non-surgical	Periodontal scaling and root planing limited to one per quadrant per two year period. Periodontal maintenance procedures limited to four per year; prophylaxis/cleanings count towards this limit.
Prosthodontics – Bridges and Dentures	Five-year replacement limit
General Anesthesia	Limited coverage per BCBSAZ dental coverage guidelines[3]
Endodontics – Root Canal	Covered
Crowns/Inlays/Onlays	Five-year replacement limit
Periodontics – Surgical	One procedure per three year period
Implants	Limited coverage per BCBSAZ dental coverage guidelines[3]
Type IV Covered Services – Orthodontia Cosmetic orthodontia not covered.	
Orthodontics (dentally necessary)	Limited coverage per BCBSAZ dental coverage guidelines.[3]

Dental benefits are available through dental providers participating in the BlueDental network. A listing of providers in the BlueDental network can be found at azblue.com.

[1] All "per year" benefits mean per calendar year

[2] Only the allowed amount, as based on least expensive available treatment (LEAT), if applicable, (and not billed charges) counts to satisfy the deductible. There may be several methods for treating a specific dental condition. All claims for restorative services such as fillings and crowns are subject to analysis for the least expensive available treatment (LEAT). Benefits for restorative procedures will be limited only to the LEAT. For these procedures, BCBSAZ will only pay benefits up to the LEAT fee. Members may elect to receive a service that is more costly than the LEAT but the member will be responsible for cost-share based on the LEAT, and will also pay the difference between the fee for the LEAT and the more costly treatment ("LEAT balance bill"). Any payment made for this LEAT balance bill will not count toward deductible or out-of-pocket maximum.

[3] BCBSAZ dental coverage guidelines are available upon request. Not all dentally necessary services are covered benefits.

PEDIATRIC DENTAL EXCLUSIONS AND LIMITATIONS

Examples of services not covered

The following is a partial list of services that are excluded or limited. Expenses for services that exceed the benefit limit are not covered. Detailed information about benefits, exclusions and limitations is in the benefit plan booklet or rider and is available prior to enrollment upon request.

- Alternative dentistry
- Athletic mouth guards
- Behavior management of any kind
- Biopsies
- Bleaching of any kind
- Complications of noncovered services
- CT scans (e.g., cone beam) and tomographic surveys
- Correction of congenital malformations except as required by Arizona state law for newborns, adopted children and children placed for adoption
- Cosmetic services and any related complications
- Dental services and supplies not provided by a dentist, except as stated in plan
- Duplicate, provisional and temporary devices, appliances, and services
- Experimental or investigational services
- Fixed pediatric partial dentures
- Genetic tests for susceptibility to oral diseases
- Inpatient or outpatient facility charges
- Laboratory and pathology services
- Locally administered antibiotics
- Major restorative and prosthodontics services performed on other than a permanent tooth
- Maxillofacial prosthetics and any related services
- Medications dispensed in a dentist's office, except as stated in plan
- Non-dentally necessary services – services that are not dentally necessary as determined by BCBSAZ. BCBSAZ may not be able to determine dental necessity until after services are rendered.
- Occlusal guards for the treatment of temporomandibular joint syndrome or sleep apnea
- Oral hygiene instruction, plaque control programs, and dietary instructions
- Over-the-counter items
- Removal of appliances, fixed space maintainers, or posts
- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliances
- Sealants for teeth other than permanent molars
- Services resulting from your failure to comply with professionally prescribed treatment
- Telephonic and electronic consultations except as required by law
- Therapy or treatment of the temporomandibular joint, orthognathic surgery, or ridge augmentation
- Tooth transplantation
- Services provided by a dentist outside your network, except for emergencies or special circumstances when use is preapproved

MULTI-LANGUAGE INTERPRETER SERVICES

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló̜ díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'ą doo bąąh ílínígóó. Ata' halne'ígíí kojį' bich'į' hodíílnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة .للتحدث مع مترجم اتصل ب .877-475-4799

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

Farsi:
اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید .[877-475-4799 تماس حاصل نمایید.

Assyrian:
ܐܢ ܐܢܬ، ܐܘ ܚܕ ܡܢ ܕܩܐ ܒܗܝܪܬ ܥܡܗ، ܐܝܬ ܠܗ ܫܘܐܠܐ ܒܘܨܝܐ ܕ Blue Cross Blue Shield of Arizona، ܐܝܬ ܠܘܟ ܙܕܩܐ ܕܩܒܠܬ ܗܝܪܐ ܘܡܘܕܥܢܘܬܐ ܒܠܫܢܘܟ ܡܓܢܐܝܬ. ܠܡܡܠܠܐ ܥܡ ܚܕ ܡܬܪܓܡܢܐ، ܩܪܝ ܠ 877-475-4799.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคณ หรอคนทคณกาลงชวยเหลอมคาถามเกยวกบ Blue Cross Blue Shield of Arizona
คณมสทธทจะไดรบความชวยเหลอและขอมลในภาษา ของคณไดโดยไมมคาใชจาย พดคยกบลาม โทร 877-475-4799

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and 1 (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance, BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/ portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1 (800) 368-1019, 1 (800) 537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

An Independent Licensee of the Blue Cross and Blue Shield Association

440712-18

D21262 01/19

18793 0119